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Protecting the Public: An Investigation of Midwives Perceptions of Regulation and the Regulator

Abstract

Objective: to investigate the perceptions of a group of midwifery registrants about the influence of regulation and the regulatory body, the Nursing and Midwifery Council, on the practice of midwives in the United Kingdom

Design: quantitative and qualitative research using an online survey and semi-structured interviews

Setting: The South East of England, which covers both urban and rural practice settings.

Participants: (a) 132 (n=70%) midwives responded to the online survey, and (b) 20 midwives participated in the semi-structured interviews

Findings: midwives were generally supportive of the need to regulate practice; however, some participants had an uneasy relationship with the Nursing and Midwifery Council and claimed to practice defensively, due to a fear that they could be removed from the register, and believed the regulator to be remote and punitive. For other participants concerns were raised about fitness to practice procedures, particularly in terms of decision making.

Key Conclusions: the participants felt that in order for midwifery regulation to be effective the regulator needs to have detailed knowledge and appreciation of the role of the midwife, and the needs of the pregnant woman.

Introduction

The pursuit of quality health care provision is something of a global phenomenon with the International Confederation of Midwives (ICM) (2011) amongst others, proposing standards by which improvements in health care may be encouraged. These standards may be broadly perceived as being part of regulatory frameworks, which are implemented at state level to strengthen the provision of quality care. In the United Kingdom (UK), the statutory regulation of midwives has influenced the practice of midwives and the care given to pregnant women for more than a century. In this context, the term regulation may be defined as the persistent and focused control by a public authority of the actions and interests of the community (Baldwin et al., 2011). Harlow and Rawlings (2009) further maintain that this control may include detailed commands and rules that are intended to have an effect on behaviour. Therefore, these authors argue that although frequently perceived as restricting the activities of individuals, in the wider sense regulation may also be viewed as a means of enabling individuals to enhance or improve their actions. Here, the role of regulatory bodies is to oversee the provision of healthcare through standard setting, monitoring, evaluation and intervention (Salter, 1999). The Nursing and Midwifery Order in 2001, created the current regulatory authority in the UK, the Nursing and Midwifery Council (NMC), and outlines a statutory duty of quality care provision, which is expressed as the aim of 'protecting the public' within the provisions of the 2001 Order. As such, the NMC is responsible for ensuring that quality care is provided by all of the registrants on its register. Whilst it is true that maternal mortality and stillbirth rates have never been lower in the UK (Knight et al., 2014; Office of National Statistics (ONS) (2014), patient safety incidents (National Health Service (NHS) England, 2014), and claims of clinical negligence in obstetrics have continued to climb (National Health Service Litigation Authority (NHSLA), 2014). This raises the question of whether the regulatory mechanisms that are designed to ensure the health and wellbeing of the pregnant woman

undermine or promote quality care and, whether the current statutory aim of 'protecting the public' is being realised. Official reports have examined the effectiveness of the NMC as an organisation (House of Commons Health Committee, 2013; Professional Standards Authority for Health and Social Care (PSA), 2015). Each of these reports identified that the NMC had weak governance structures in areas such as leadership and highlighted particular concerns about fitness to practice procedures. There is little empirical data within the literature, which considers the midwives' perceptions of regulation and the NMC, particularly in relation to whether or not the regulator was functioning effectively in the view of midwives. Within this limited literature, a reader poll conducted by the Nursing Standard in 2013 found that several nursing respondents, as a result of personal experiences, had little confidence in the NMC and its ability to ensure robust disciplinary procedures. Further research exists regarding other health care professional groups and their perceptions of regulation and regulatory, most notably in relation to the medical profession (Morrison and Wickersham 1998; Sharp et al., 2002; McGivern and Fischer, 2010). These studies, which were undertaken in the United States of America, found that professional regulation was often associated with chastisement and punishment. These studies do not relate directly to the midwifery profession, and therefore cannot be generalised to midwives in the UK, they do nevertheless draw attention to the negative perceptions of regulators and their ability to positively influence the behaviour of registrants as is suggested in the regulation literature (Harlow and Rawlings, 2009).

Aim

The study, which was undertaken as part of a doctoral thesis, investigated the perceptions of a group of midwives, in terms of the influence of regulation and the regulatory body, the Nursing and Midwifery Council, on the practice of midwives in the United Kingdom.

Methodology

The study was designed to offer a socio-legal exploration of midwifery governance. Ewick and Silbey (1998) suggest that sociolegal studies may be defined as the exploration of the function of law in shared societal situations in an attempt to understand the influence that each has on the other. The study focused on the way in which midwives perceive governance and its influence on their practice in an attempt to understand the impact that regulation has on the facilitation of safe care in practice. Moreover, by employing a strategy, which examined the 'lived experience' of the midwives, their understanding of regulation, may be described and analysed (Van, Manen, 1990). This would facilitate a more nuanced approach in terms of the midwifery participants and their perceptions of midwifery regulation, whereby the midwife's actions may be understood from the individual's own perspective. The research question upon which the study was based was: 'do midwives believe that the current regulatory frameworks that govern midwifery practice support or undermine the protection of the public'. As this was a complex research question a mixed methods approach was employed that combined both quantitative (in the form of an online survey) and qualitative (semi-structured interviews) research techniques (Flick, 2011). Johnson et al. (2007) suggest that such a strategy is worthwhile when, as in the current study, the research question requires a realistic and contextual understanding of the participant's opinions and views. Within the research, the qualitative aspect of the study built upon the themes that emerged from the quantitative survey (Fetters, 2013). Uniting different research methods through triangulation in this way, whereby the strengths of each research method was drawn upon, allowed the findings to be mutually illuminating and helped to ensure rigour in terms of the constructs that were being examined (Bryman, 2006). Additionally although I had prior knowledge of the regulation of midwifery as a practising midwife myself which enabled me to have

commonality with the participants, I had no influence over the participants, which therefore did not affect the collection of data for this study (Dwyer and Buckle, 2009).

Sample

In the study, a purposive approach was used, as this enabled the selection of participants based on their knowledge and experience of the governance of midwifery (Cleary et al., 2014). This process helped to ensure that the participants were representative of a wide range of qualified midwives working in The South East of England (Bryman, 2012). In the study, which had a 70% (n=132) response rate to the online survey and where 20 semi-structured interviews were conducted, the sample comprised of midwives who worked in the National Health Service (NHS) and independent midwives, together with midwives who had been a supervisor, and those who had not. Additionally, the length of time that the participants had been a qualified midwife was considered an important factor in terms of recruitment. Within the sample of NHS midwives, participants had a wide range of experience that included those with a management role as well as more junior midwives. An invitation email was sent to the potential participants that contained information about the research and a link to the online survey. This invitation email provided the participants with the opportunity to contact the researcher via email if they wished to take part in a follow up semi-structured interview. Additionally, following the completion of the interview, the participants were asked to recommend other participants who met the study criteria. This method of recruitment is referred to as snowball or chain sampling as the number of participants in the study is increased as each new person is recruited to the study (Hennink et al., 2011). The advantage of this type of sampling is that recruitment to the study takes place through a familiar and reliable individual who can outline the process to potential participants and therefore increase participation. In doing so, the sample provided the opportunity to undertake a detailed investigation of the perceptions of the regulatory frameworks that govern the practice of a cohort of midwives practising in the South East of England between the period of March 2012 and March 2013.

Data Collection

The online survey contained three sections: the first set of questions related to individual participant data, the second group dealt with midwifery specific legislation and the third with clinical guidelines. Some questions had a number of predefined answers where participants were required to choose one response, whilst other questions permitted the participant the opportunity to choose more than one response. Additionally some questions had a free form section, which enabled the participant the opportunity to provide qualitative responses. The questions were initially tested by distributing the questionnaire to a small sample of midwives prior to it being made available to the participants in the study, this was undertaken to ensure that the questions were focused appropriately in relation to the research question (Bryman, 2006). As a result, some minor adjustments were made to the questionnaire before it was distributed to the participants in the study. The online survey was distributed to 192 midwives working in the NHS and those who were independent midwives. The survey achieved a 70% response rate, which was considered useful in terms of integrity within the period allowed for the study (Fincham 2008). The survey enabled the collection of data from a larger number of participants than would have been achievable using semi-structured interviews alone. The semi-structured interviews were conducted with twenty participants. The use of semi-structured interviews as a method of data collection was utilised as it permitted the participants the space and

opportunity to explore in detail their views on regulation and governance (Hammersley, 2013). It was thus envisaged that the data collected would be deep and probing and would produce in-depth images of governance and regulation in action (Bryman, 2008). Prior to conducting the interviews, a schedule of broad questions was devised which enabled the participant to fully explore the concepts under discussion from a variety of different positions, whilst enabling the opportunity for further questions to be asked in response to significant answers given by the participant (Kvale and Brinkmann, 2009). The interviews were typically between forty and ninety minutes in duration and were recorded and transcribed with the consent of the participant. In a further attempt to ensure that the sample reflected the wider population of midwives working in the UK, after ten interviews had been conducted, the sample was reviewed. Accordingly, it was identified that there was a need to recruit more midwives who had been qualified less than ten years and who worked in the NHS. Thus, the specific criteria for the study amongst midwifery registrants who had a diverse experience of regulation in practice could be maximised.

Data Analysis

The analysis of the data was commenced soon after the survey and semi-structured interviews were completed (Silverman, 2006). The online survey was analysed and coded, and as a result, concepts arose in the form of numerical data, which was represented as percentages in terms of the different constructs within the survey. The free form questions from the survey and the transcripts from the semi-structured interviews were coded prior to analysis, as this enabled the reduction of the volume of the data into manageable levels that could then be examined in detail (Denzin and Lincoln, 2000). In the survey, because of the way that the questions were structured, the data generated provided a broad picture of the participants' experience and perceptions of governance and regulation. In comparison, the data from the semi-structured interviews enabled the development of this general depiction into a more in-depth appreciation of the midwives' understanding and views of midwifery governance. In the study, the data was analysed and grouped into themes, which arose from the survey and transcripts, which appeared to be directly related to the focus of the research (Bryman, 2012). As a result of this process, key themes emerged which included: general perceptions of the regulator and regulation; the functionality of the NMC; the fear of removal from the NMC register; the provision of competent practitioners through regulation. Braun and Clarke (2006) suggest that thematic analysis may therefore be seen as progressing the analysis of data as it requires the researcher to reflect on the early codes that arose from the analysis of the survey data and transcripts with the aim of understanding the connections, which linked them together. It was important that the analysis was founded on a critical scrutiny of the data and avoid anecdotalism (Silverman, 2006). Within, qualitative research the quest is for in-depth knowledge that may not be related to the size of the sample. Bryman (2012) states that the challenge when conducting qualitative research in terms of the data that is produced, is that explanations and analysis may be based on a number of limited examples, which might not be representative of the findings, in general terms. Therefore, throughout the presentation of the data when quotations are used that are broadly representative of a significant number of participants this is acknowledged in the text. Similarly, when extracts have been employed which are characteristic of the minority of participants this is also recognised in the text.

Ethical Considerations

The study was scrutinised and approval for it given by the Research Ethics Advisory Group within the University of Kent Law School, as well as from the local NHS Trusts from where most of the participants were drawn, prior to the commencement of the study. This was in accordance with guidance from the Department of Health (DH) (2011), which recommends that research that involves NHS staff who are recruited as a consequence of their professional role does not necessitate NHS REC (Research Ethics

Committee) review, but does however require authorisation from the relevant local NHS Trust Research and Development (R and D) offices. In order to ensure that the principles of consent, confidentiality and data protection were adhered to throughout the study, a variety of strategies were employed. The online survey was constructed using a secure server that encrypted responses. As a result, participant data was kept anonymised. Equally, the invitation email that was sent to participants was accessed via a separate link contained within the email. This ensured that anonymity and confidentiality was maintained, as the researcher did not have access to the participants' responses via this email. In terms of the semi-structured interviews, potential participants were given an information sheet prior to the interview being conducted, which enabled the clarification of any questions the individual might have. Before the commencement of the interview the participant was asked to sign a consent form, and informed that, they could withdraw from the study at any point during the research process. All participant data from the semi-structured interviews was anonymised and when participant quotes are used in the reported findings pseudonyms are used. All of the data from the study stored in accordance with UK data protection legislation (Data Protection Act 1998).

Findings

The data from the online survey and semi-structured interview was compared and categorised (Hennink et al., 2011). This process enabled the development of two key themes, which were: the value and influence of the NMC; and, ensuring safe and competent practitioners. These themes will be presented below and are illustrated with quotations from both the survey and the semi-structured interview participants.

The Value and Influence of the NMC

Within the survey, when given a variety of choices about the aim of legislation, many midwives, (75 per cent (n=100)) felt that it protected the public and improved standards of midwifery practice, whilst 66 per cent (n=88), believed that it increased patient safety. Here, the participants were broadly supportive of the need for healthcare regulation and for midwifery practice to be regulated; they were nevertheless concerned about the effectiveness of the NMC. In the data, it was evident that several participants were concerned about the authority of the NMC on them as individual registrants. In the survey, whilst 37 per cent (n=49) of respondents felt that the fear of removal from the NMC register created a positive effect on care provision other participants were less convinced. When the survey respondents were asked to give examples of how this fear might affect practice the responses were noteworthy:

'Midwives especially newly qualified midwives can feel that they are held to ransom, there is a huge issue around autonomy and responsibility linked with having worked hard for three years, and as a result may decide to 'just go along with the norm', and not challenge practice or guidance that may not be in line with best practice because it's easier not to challenge and possibly be referred to the NMC.' (NHS, 11–20 yrs.).

'It generates protective practice...to the detriment of being 'with woman'...the true essence of midwifery.' (NHS, 0–5 yrs.).

'Midwives will document absolutely everything to cover themselves which takes time away from being with woman. The old saying that 'if it's not written/ recorded it didn't happen' has damaged midwives autonomy.' (NHS, 11–20 yrs.).

In the last quotation the participant is referring to the guidance on documentation given to health care professionals (Department of Health, 2010), which encourages the midwife to record in detail all care provided to pregnant women.

The comments from participants in the interviews also appeared to echo the views from respondents to the survey. These are some examples:

‘I would say that it [the regulatory framework] makes midwives cautious.’ (Nina, NHS, 11–20yrs.).

‘We are protecting ourselves most of the time...it makes you defensive...midwifery is not midwifery anymore, things have changed.’ (Cathy, NHS, 0–5yrs.).

‘Defensive practice...that is what it's all about, we don't practice how we feel we should...midwives are toeing the line because they are frightened of losing their registration... and that's your livelihood isn't it?’ (Lucy, NHS, 11–20yrs.).

In these narratives, the common thread is one of concern regarding the power of the NMC to remove registrants from its register, and the impact on practice that this anxiety creates for midwives, which is epitomised as defensive practice. When explored in more detail the defensive practice that is produced as a result of the fear of removal from the NMC register is multifaceted. For several participants this impact included limiting decision-making, avoidance of caring for women in challenging situations, and undermining midwifery confidence in their own competence:

‘I wouldn't want to do anything which would jeopardise my registration...it's like big brother watching you...every decision I make, every time I sign something I think I could potentially go to the NMC.’ (Jean, NHS, 0–5 yrs.).

‘Everything you do your accountable for ...we're very much a stick orientated profession...it is very much a case of ‘watch out’ because you're accountable, rather than ‘isn't it fantastic that you're accountable because of all the knowledge you have’ ...and that ‘stick’ impacts on the decisions you make....’ (Samantha, NHS, > 20 yrs.).

‘Being aware of the NMC has caused me to act differently...there are some decisions that I do not want to make on my own, so I will involve other people.’ (Lucy, NHS, 11–20 yrs.).

In each of these quotes, the possibility of referral and removal from the NMC register is an influential component in terms of decision making in practice. Other narratives draw attention to additional difficulties that the fear of removal evokes for participants. For some midwives it is the responsibility of caring for women with complex needs, which emerged as being problematic in this context:

‘We all know midwives who avoid stressful situations, we all know midwives that don't go into the room when the emergency bell goes off.’ (Louise, NHS, > 20yrs.).

Whilst several midwives spoke in terms of being anxious about making errors in practice:

‘When I was working on the wards I adapted my practice so I wouldn't get into trouble.’ (Mary, NHS, 6–10 yrs.).

‘Midwives always talk about how stressed and worried they are...and that they don't want to make a mistake...and that there will be big trouble for making a mistake...I have heard midwives say ‘I might be removed from the register if something goes wrong’. (Kate, NHS, > 20 yrs.).

'The first thing they say when it has been highlighted that they have been doing something wrong is 'I will lose my registration won't I'? Of course, the vast majority of them do not...but I do think that is what they think when they are in trouble.' (Amy, NHS, > 20 yrs.).

Although the fear of being removed from the NMC register appeared in the discussions to be limiting for many of the midwives, it is interesting that both Amy and Kate identify that the perceived fear in relation to errors and mistakes made in practice is disproportionate to the number of midwives who are removed from the register. Thus for many participants, awareness of their accountability to the NMC was viewed as an obstacle to efficient midwifery practice.

Ensuring Safe and Competent Practitioners

The regulation of midwives has as its focus woman safety (Spencer-Lane, 2014), and fitness to practice hearings within the regulatory framework therefore play a significant role in ensuring the protection of the public (Nursing and Midwifery Order, 2001). Within the data, some participants felt that the lack of effective management created challenges:

'I don't think they [the NMC] are fully effective in their role...there have been issues with the NMC and I don't think they are fully ensuring safety.' (Megan, NHS, 11–20 yrs.).

'I think they [the NMC] have lost the confidence of the public and the profession partly because of the problems they've had and the changes in leadership.' Kate (NHS, > 20yrs.)

These remarks are characteristic of the frequently repeated concern within the data regarding the NMC's ability to manage its core function of fitness to practice competently. As such it appears that whilst the aim of the NMC is to safeguard the pregnant woman, for midwives in this study this ability appears greatly reduced because of management problems within the organisation.

When this unease with the NMC was examined in more detail within the data, concerns regarding fitness to practice decision-making processes emerged as being particularly challenging for participants. Within the study midwives were apprehensive about whether or not the decision making process was rigorous:

'I have big concerns about them...I've been to one hearing and read the transcript of another...they either stick to the NICE guidance and say 'this midwife didn't do this, this and this' or they don't have a clue what normal practice is...they seem a bit of a kangaroo court...which hugely bothers me, because then you're at the mercy of the people on the day...I'm not sure how fair that is... particularly when it's about specifics of care, I think midwives can get hauled over the coals for specifics when maybe it's actually that their philosophy doesn't quite fit with what's considered main stream.' (June, Ind. > 20yrs.).

'I've seen fitness to practice panels which were very scary where they quite literally looked at what was written in the rules and stated that the midwife had broken those rules without taking anything else into consideration. It was so far removed from the ward...from what was going on.' (Mary, NHS, 6–10 yrs.).

For these midwives there appears to be a perception of limited understanding on the part of fitness to practice panellist members of the provision of care within the clinical environment. Some participants went further, suggesting that government strategy for the NHS and the maternity services was in part responsible for this type of decision making within fitness to practice hearings. Two participants made specific reference to endemic underfunding:

'I witnessed a hearing...and I remember thinking 'that person hasn't gone to work that day intending to harm that baby'...there are always other things involved...it was a busy shift...when you take a person out of the situation and pull them apart you can almost sympathise with the situation, the dilemma that they're in. The NMC has got a difficult job...I think they're carrying the can for the government not putting enough money into the NHS...we know how understaffed units are...wards running with just one midwife...there isn't enough staff, there isn't enough beds and it's dangerous. I think in the bigger picture, that funding has got a lot to do with it.' (Lucy, NHS, 11–20yrs.).

'I think it's the government passing the buck...they don't put money into the system but they still want everybody to have the same standard of care and you can't do it...so they think 'Let's pass the buck to the NMC because practitioners are not doing their jobs effectively.' (Lilly, NHS, 0–5 yrs.).

Another factor which participants perceived to impact on the decisions made at fitness to practice panels was the inclusion of lay members, who are encouraged to take an active part in the decision making process. Some of the midwives felt that the inclusion of the public would guarantee impartiality and equanimity in decision-making and ensure the evolution and development of care between the service user and the healthcare professional:

'Having a lay person would help them to be fairer, more reasonable, a bit like a jury...they would come with a different perspective'. (Ruth, NHS, 6–10 yrs.).

'A lay person on most panels would be good because they're neutral, independent people.' (Jean, NHS, 0–5 yrs.).

However, other participants were more doubtful about the efficacy of lay members on fitness to practice panels:

'You need people that are completely objective, but how you can be objective when you're hearing a case where harm has been done to a patient by a practitioner...you immediately want to blame the practitioner and say 'it must be the practitioner, because it wasn't the patient.' (Lucy, NHS, 11–20 yrs.).

'I'm concerned that in midwifery cases you might get somebody who's had no experience of childbirth...so how can someone like that be representative of the lay side of things on a childbirth issue? How can they understand what's quite often complex decision making...I would suggest it would be beyond them...if you're going to have lay people...they should be well qualified and come from organisations that represent lay members around childbirth issues...that would be useful.' (Laura, Ind. > 20yrs.).

Here, the lack of understanding and, on occasion, limited personal experience was perceived to be difficult particularly in relation to decision making within fitness to practice hearings.

Discussion

The aim of this study was to investigate the perceptions of a group of midwives, in terms of the influence of regulation and the regulatory body, the Nursing and Midwifery Council, on the practice of midwives in the United Kingdom. The data revealed several key findings. Participants were broadly supportive of regulation perceiving that it helped to protect the public, improved standards of care and increased patient safety. However many of the participants were fearful of being removed from the NMC register which led to defensive practice, limited decision making and a reduction in confidence of their own skills and competence. Participants also expressed concern regarding the

NMC's ability to fulfil its core function of protecting the public effectively, particularly in relation to fitness to practice procedures.

Within the participant narratives, the influence of the regulatory framework on the provision of care was clear for many. Whilst the midwives were generally understanding of the need for regulatory structures, the awareness of what is meant by safe care was seen as being complex and multifaceted. A key issue within this concept of safe care was the perception that the regulator had a limited appreciation of issues related to service provision. Funding of maternity services, which has been highlighted in the literature (Sandall et al., 2011) as affecting the quality and provision of care, may also affect decision making at the NMC. This may result in the perception of a regulator who may penalise individual midwives who attempt to offer care in challenging circumstances, for fiscal failings in the wider NHS. Additionally this may be compounded by the regulatory codes and guidelines, which are issued periodically by the NMC, to enforce conformity and regulate the behaviour of professionals (Yeung and Dixon Woods, 2010), without acknowledging that the environment within which care is offered might also influence the actions of the professional. Whilst there is a paucity of existing empirical research on midwifery registrants' perceptions of the NMC, in the study the regulator was often understood to be remote and lacking familiarity with the practice of midwives. This detachment was believed to have had a bearing on the NMC's ability to fulfil its statutory obligation of protecting the public.

The notion of accountability was also a significant concern in the discussion of the NMC. Although the regulator has a statutory duty to protect the public, official reports (House of Commons Health Committee, 2013) demonstrate that the NMC has performed inadequately in terms of fitness to practice processes, which has led to questions about its ability to be responsible for the practice of its registrants (PSA, 2015). Whilst much of the literature (Baldwin et al., 2011; Savage and Moore, 2004; ICM, 2014) and NMC guidance, discusses concepts of accountability, there is limited empirical data on the impact of regulatory accountability from a midwifery perspective. In the study, many participants had a heightened sense of cognizance of their own accountability to the regulator but were unclear about regulatory processes more generally. This appeared to generate a disproportionate fear of being removed from the register, which led to overly cautious decision-making and self-protective practice particularly in challenging situations. Here, the uncertainty that is generated in relation to regulatory procedures has the potential to generate a professional identity, which is dislocated from reality (Maranon and Pera, 2015). In Becker et al. (1961) seminal research fear and vulnerability appeared to influence the socialisation process and the subsequent actions of the individual. This may be applied to participants in the current study who behave defensively in reaction to their anxieties about the NMC, which is interesting, as whilst defensive practice is not supported by the NMC (2015), the authority of the NMC appears to provoke practice that may not be in the interest of the pregnant woman.

In the data, the concept of defensive practice particularly in relation to caring for women who have complex needs was problematic. Here defensive practice may be defined as practice that the midwife employs in order to shield themselves from the risk of blame and punishment (Black, 1990; Clements, 1991). In the study, a number of participants were unwilling to take responsibility for the provision of care because of the fear that there might be a poor outcome for which they might be held to be culpable. This mirrors earlier research by Curtis et al. (2006), which explored why midwives ceased to practice in the UK, discovering evidence that some midwives feared condemnation and punishment if mistakes were made when providing care and left the profession as a result. The findings from the current study emphasize that for those participants, who chose to remain, rather than leaving the profession, practicing defensively might be a way to avoid the criticism and penalties that they fear.

This fear of reprisal for poor outcomes may also be impacting on the midwives relationship with the woman. In the current study, the concept of woman centred care and being 'with woman' was seen as pivotal to the quest to provide quality care for the overwhelming majority of midwives. The woman centred care agenda, which seeks to encourage the pregnant woman to participate in decision making, focusing on her individual needs and expectations, has been part of government policy for over twenty years (Cumberledge, 1993). This policy is consistent with neoliberal tenets that endorses the patient as a consumer of healthcare and which enables the service user voice within the provision of care (Deery and Kirkham, 2006). Here there is an emphasis on the woman and midwife working together in partnership in an endeavour to facilitate the provision of safe and effective care (Department of Health, 2012). However, tension emerges in terms of woman centred care particularly when midwives avoid providing care to women in challenging circumstance. In these circumstances, it is important that the connection between the woman and midwife be supported by regulatory mechanisms that recognise the unique nature of the relationship. Interestingly, in the study participants did not appear to connect the NMC with the woman centred care agenda. The reason for this apparent lack of connection in the data was unclear, it is possible however that this might be a further indication of the limited appreciation of the work of the midwife that the participants believed the NMC had.

Government policy which focuses on the reduction of welfare budgets and the curtailment of public sector spending (White, 2000), may also have a direct influence on another aspect of regulation, namely fitness to practice hearings. The NMC is tasked with examining the registrant's actions in practice, which may have been affected by other factors beyond the control of either the regulator or the regulated, without recognising the effect of the external issues on the practitioner's behaviour. In the study, this apprehension focused on the judgements and decisions that were made by panel members in terms of actions in practice. Membership of fitness to practice panels includes both professional and non-professional personnel (NMC, 2001). The inclusion of the lay public in midwifery regulation has been in evidence since the enactment of the Nursing and Midwifery Order in 2001. Such strategies are consistent with neoliberal 'Third Way' tenets where shared decision making at all levels of health care provision is perceived to facilitate the delivery of safe care (Ruhl, 1999; PSA, 2013). This approach is also witnessed in other models of midwifery regulation globally including that of Zealand Health Practitioners Disciplinary Tribunal (HPDT), 2009 where lay members and appointed by the Minister for Health. However, although the NMC provides training and guidance on fitness to practice issues and procedures (NMC, 2012), given the complex nature of errors in practice, it is unclear whether this training programme is sufficient. It is therefore unsurprising that some of the participants in this study expressed concern regarding the potential for problems to occur in the decision making processes within these panels. In these circumstance participants believed that the outcome of fitness to practice hearings may thus be flawed and not supportive of either the public or the registrant, albeit that this may only be representative of midwives in this study.

In recent times key reports (Fielding et al., 2010; Parliamentary and Health Service Ombudsman (PHSO), 2013) have highlighted ineffective governance strategies which have had an impact on the standard of care provided to pregnant women. The recommendations that have been made to tackle these concerns include addressing the traditional model of collegiate midwifery regulation, which is believed to insulate and protect those being regulated (PHSO, 2013). Indeed, in January 2015, The NMC voted to accept the (Baird et al., 2015) proposals to end the statutory element of the supervision of midwives. Consequently, the NMC will have sole responsibility and accountability for the core function of regulation, namely fitness to practice processes. This shift in the regulation of midwifery is potentially troubling, given that whilst participants are supportive of regulation in order to ensure that care is of a high standard, apprehension remains about the NMC's ability to fulfil its functions competently.

Limitations of the Study

Whilst official reports (PSA, 2015) have raised doubts about the NMC's ability to accomplish its statutory role in recent years there is limited empirical research that examines midwifery registrants' views of regulation and the regulatory body the NMC. One limitation of the current study is therefore that this paucity of evidence hampers the comparison of results. Another limitation is the small sample size, which cannot be extrapolated to the wider population of midwives in the UK. Additionally the participants in the semi-structured interviews were included by contacting the researcher by email, or who were recommended by a midwife who had also been interviewed. This had the potential to create selection bias as midwives with a pessimistic perspective might want to share those views about the influence of regulation and the regulator, and therefore the findings from the qualitative research might be distorted as a consequence of these negative opinions. As such whilst the study has provided some insights into the experiences of this cohort of midwives and has added to the small body of empirical research in this area it is nevertheless incomplete. This preliminary research could therefore be utilised as the foundation for further research, which examines the perceptions of midwifery registrants elsewhere in the UK, and in doing so achieve a more nuanced understanding of the impact that regulation has on the practice of midwives.

Conclusion

Within the research, it was evident that the participants believed that the regulatory frameworks that regulate the practice of midwives in the UK facilitated the provision of safe quality care. However, it was also apparent that, in the view of the participants, that there are challenges in terms of the care offered to pregnant women that the regulatory processes do little to resolve. In the study, participants were concerned that the NMC was unfamiliar with the practice of midwives currently on its register. It is essential then, that in order for regulation to be effective that the regulatory authority has a detailed knowledge and appreciation of the role of the midwife and the needs of the pregnant woman. Such a strategy would help to facilitate regulation that is responsive and effective.

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